

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of \$702.00 for date of service, 07/31/01.
- b. The request was received on 03/11/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. Initial TWCC 60
 1. EOB
 2. HCFA-1500
 3. Medical Records
 - b. Additional documentation requested on 10/14/02 and received on 10/18/02
 1. Position statement dated 01/17/02
 2. Medical Records
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 10/21/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

3. Notice of "Supplemental Additional Information Submitted by Requestor" is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 01/17/02

"During the initial examination, this patient reported pain with radiation. Clinical findings were consistent with the need to rule out radiculopathy and/or peripheral nerve injury. Due to the findings of the examination, along with the clinical presentation, electrodiagnostic testing was medically necessary to further evaluate the extent of injury to the aforementioned regions."

2. Respondent: No response statement submitted.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/31/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$702.00 for services rendered on the date above.
4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$0.00 for services rendered on the date above and denied reimbursement as "OUTSIDE SCOPE OF PRACTICE FOR D.C. PER NURSE REVIEW".
5. Per the Requestor's Table of Disputed Services, the amount in dispute is \$702.00 for services rendered on the dates of service in dispute above.
6. The General Instructions to the Commission's Medical Fee Guideline provides: "The MFG does not supersede scope of practice limitations for HCP specialties. The listed maximum allowable reimbursement (MAR) only apply when a licensed HCP is performing those services within the scope of practice for which the provider is licensed, or when a non-licensed individual is rendering care under the direct on-site supervision of a licensed HCP." Consequently, reimbursement is limited to health care providers performing services within the scope of practice for which the provider is licensed.
7. The Commission's policy with respect to scope of practice was announced in the Preamble to the 1996 Medical Fee Guideline as follows: "The commission disagrees that this guideline should restrict billing and collection of fees for test such as EMGs, NCVs, surface EMGs, and SSEPs. The Medical Fee Guideline is not a treatment guideline, it is therefore, inappropriate for it to instruct regarding diagnosis, patient care or treatment outcomes. It has been the policy of the commission not to supersede the restrictions of professional licensing boards. It is the role of a licensing board to establish parameters within its trade, which defines the roles and responsibilities of the care providers. In the introduction to the General Instructions Section of the Medical Fee Guideline reimbursement is limited to HCPs performing services within the scope of practice for which the provider is licensed."
8. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
07/31/01 07/31/01 07/31/01	95900 95904 95935	\$256.00 \$128.00 \$318.00	\$0.00 \$0.00 \$0.00	OUTSIDE SCOPE OF PRACTICE FOR D.C.	\$64.00/nerve \$64.00/nerve \$53.00	MFG General Instructions- Introduction; MFG; MGR (IV) (B) (D): CPT Descriptor	<p>The Medical Fee Guideline does not supersede scope of practice limitations for HCP specialties. Refer to paragraphs 5-8.</p> <p>For CPT Code 95900, reimbursement of \$256.00 (\$64.00 x 4 = \$256.00) is recommended.</p> <p>For CPT Code 95904, reimbursement of \$128.00 (\$64.00 x 2 = \$128.00) is recommended.</p> <p>For CPT Code 95935, reimbursement of \$318.00 (\$53.00 x 6 = \$318.00) is recommended.</p>
Totals		\$702.00	\$0.00				The Requestor is entitled to a total reimbursement in the amount of \$702.00 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$702.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 9th day of December 2002.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division
DT/dt